

		FOR OHF USE					

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2004  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2004)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007880

Facility Name: Country Health

Address: RR 1 Box 14 Gifford 61847  
Number City Zip Code

County: Champaign

Telephone Number: ( 217 ) 568-7362 Fax # ( )

IDPA ID Number: 376064916

Date of Initial License for Current Owners: 01/01/70

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:  
Name: Craig Ater Telephone Number: ( 309 ) 823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)	Carol Ruthenburg		
	(Title)	Administrator		
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)	Craig L. Ater Senior V.P. and Chief Financial Officer		
	(Firm Name & Address)	Heritage Enterprises		
	(Telephone)	( 309 ) 823-7135	Fax #	( )
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number Country Health

# 0007880 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,574	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,574	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	9,753	12,408	1,627	23,788	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	9,753	12,408	1,627	23,788	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.03%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

xx

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

xx

I. On what date did you start providing long term care at this location?

Date started 01/01/70

J. Was the facility purchased or leased after January 1, 1978?

YES

☐

Date

NO

xx

K. Was the facility certified for Medicare during the reporting year?

YES

xx

NO

☐

If YES, enter number

of beds certified

and days of care provided

1,627

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL

xx

MODIFIED

CASH\*

☐

CASH\*

☐

Is your fiscal year identical to your tax year?

YES

xx

NO

☐

Tax Year: Fiscal Year:

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	165,034	9,566		174,600		174,600		174,600			1
2	Food Purchase		116,975		116,975		116,975		116,975			2
3	Housekeeping	86,862	13,175		100,037		100,037		100,037			3
4	Laundry	43,953	11,345		55,298		55,298		55,298			4
5	Heat and Other Utilities			78,360	78,360		78,360		78,360			5
6	Maintenance	49,119	34,325	32,245	115,689		115,689		115,689			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	344,968	185,386	110,605	640,959		640,959		640,959			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	953,084	54,331	193,614	1,201,029		1,201,029		1,201,029			10
10a	Therapy		155,197	152,035	307,232	(72,656)	234,576		234,576			10a
11	Activities	45,380	4,504		49,884		49,884		49,884			11
12	Social Services	45,652	2,180	1,430	49,262		49,262		49,262			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,044,116	216,212	354,279	1,614,607	(72,656)	1,541,951		1,541,951			16
	<b>C. General Administration</b>											
17	Administrative	61,959			61,959		61,959		61,959			17
18	Directors Fees											18
19	Professional Services			134,415	134,415		134,415	(8,971)	125,444			19
20	Dues, Fees, Subscriptions & Promotions			91,233	91,233	(48,728)	42,505	(30,520)	11,985			20
21	Clerical & General Office Expenses	114,820	8,335	14,021	137,176		137,176		137,176			21
22	Employee Benefits & Payroll Taxes			303,450	303,450		303,450		303,450			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			8,563	8,563		8,563	(6,564)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			138,666	138,666		138,666		138,666			26
27	Other (specify):*			970	970		970	(50)	920			27
28	<b>TOTAL General Administration</b>	176,779	8,335	693,317	878,431	(48,728)	829,703	(46,105)	783,598			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,565,863	409,933	1,158,201	3,133,997	(121,384)	3,012,613	(46,105)	2,966,508			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			100,568	100,568		100,568		100,568			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,409	13,409		13,409	(450)	12,959			35
36	Other (specify):*											36
37	TOTAL Ownership			113,977	113,977		113,977	(450)	113,527			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					72,656	72,656		72,656			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					121,384	121,384		121,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,565,863	409,933	1,272,178	3,247,974		3,247,974	(46,555)	3,201,419			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(450)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(6,564)	24		19
20	Contributions	(50)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,971)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(30,520)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,555)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (46,555)		37

\*These costs are only allowable if they are necessary to meet minimum  
licensing standards. Attach a schedule detailing the items included  
on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Country Health

ID#0007880

Report Period Beginning:01/01/2004

Ending:12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		(450)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15			33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(50)	27	20
21				21
22		(8,971)	19	22
23				23
24		0	27	24
25		(30,520)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,991)		49



## Summary B

12/31/2004

	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
Capital Expense	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
D. Ownership												(to Sch V, col.7)	
Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	(450)	0	0	0	0	0	0	0	0	0	0	(450)	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
<b>TOTAL Ownership</b>	<b>(450)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(450)</b>	<b>37</b>
<b>Ancillary Expense</b>													
<b>E. Special Cost Centers</b>													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(46,555)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,555)</b>	<b>45</b>



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V	10a				100.00%			2
3	V								3
4	V	19				100.00%			4
5	V								5
6	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	100.00%			6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$	Heritage Enterprises, Inc.	100.00%	\$	\$	#VALUE!15
16	V								#VALUE!16
17	V								#VALUE!17
18	V								#VALUE!18
19	V								#VALUE!19
20	V								#VALUE!20
21	V								#VALUE!21
22	V								#VALUE!22
23	V								#VALUE!23
24	V								#VALUE!24
25	V								#VALUE!25
26	V								#VALUE!26
27	V								#VALUE!27
28	V								#VALUE!28
29	V								#VALUE!29
30	V								#VALUE!30
31	V								#VALUE!31
32	V								#VALUE!32
33	V								#VALUE!33
34	V								#VALUE!34
35	V								#VALUE!35
36	V								#VALUE!36
37	V								#VALUE!37
38	V								#VALUE!38
39	Total			\$			\$0	\$ *	#VALUE!39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$	Heritage Enterprises, Inc.		\$	\$	#VALUE! 15
16	V								#VALUE! 16
17	V								#VALUE! 17
18	V								#VALUE! 18
19	V								#VALUE! 19
20	V								#VALUE! 20
21	V								#VALUE! 21
22	V								#VALUE! 22
23	V								#VALUE! 23
24	V								#VALUE! 24
25	V								#VALUE! 25
26	V								#VALUE! 26
27	V								#VALUE! 27
28	V								#VALUE! 28
29	V								#VALUE! 29
30	V								#VALUE! 30
31	V								#VALUE! 31
32	V								#VALUE! 32
33	V								#VALUE! 33
34	V								#VALUE! 34
35	V								#VALUE! 35
36	V								#VALUE! 36
37	V								#VALUE! 37
38	V								#VALUE! 38
39	Total			\$			\$0	\$ *	#VALUE! 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$		\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Gifford State Bank		xx	Building Improvement		7/1/2004	\$ 15,500	\$ 15,500	7/1/2005	0.0200	\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 15,500	\$ 15,500			\$	9	
	B. Non-Facility Related*												
10	Interest Income											10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 15,500	\$ 15,500			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999		8	
		2000		9	
		2001		10	
		2002		11	
		2003		12	
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.



IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Health COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0007880

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

## X. BUILDING AND GENERAL INFORMATION:

**A. Square Feet:** 34,102 **B. General Construction Type:** Exterior Brick/Wood Frame **Number of Stories** 1

**C. Does the Operating Entity?** ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)**

**D. Does the Operating Entity?** ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)**

**E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

## Pleasant View Apartments

**F. Does this cost report reflect any organization or pre-operating costs which are being amortized?** ☐ YES ☒ NO  
If so, please complete the following:

**1. Total Amount Incurred:** \_\_\_\_\_ **2. Number of Years Over Which it is Being Amortized:** \_\_\_\_\_

### 3. Current Period Amortization: 4. Dates Incurred:

**Nature of Costs:** \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

### A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	land	425,100	1969	\$ 27,031	1
2					2
3	TOTALS	425,100		\$ 27,031	3

Facility Name &amp; ID Number    Country Health

#    0007880

Report Period Beginning:

01/01/2004    Ending:    12/31/2004

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	89				\$ 744,720	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	1976 Improvements		1976		10,703						9
10	1977 Improvements		1979		15,361						10
11	1978 Improvements		1977		25,766						11
12	1979 Improvements		1978		6,618						12
13	1980 Improvements		1980		30,846						13
14	1981 Improvements		1981		18,567						14
15	1982 Improvements		1982		4,662						15
16	1983 Improvements		1983		28,833						16
17	1984 Improvements		1984		6,700						17
18	1985 Improvements		1985		33,953						18
19	1986 Improvements		1986		23,775						19
20	1987 Improvements		1987		40,603						20
21	1988 Improvements		1988		163,565						21
22	1989 Improvements		1989		50,581						22
23	1990 Improvements		1990		111,695						23
24	1991 Improvements		1991		36,516						24
25	1992 Improvements		1992		26,816						25
26	1993 Improvements		1993		21,383						26
27	1994 Improvements		1994		12,384						27
28	1995 Improvements		1995		5,450						28
29	NURSE CALL SYSTEM		1996		6,349						29
30	DINNING ROOM EXPANSION		1996		10,109						30
31	Dinning Room Remodel		1997		6,121						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					56,537		56,537		1,278,031	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dinning Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,891,513	\$ 56,537		\$ 56,537	\$	\$ 1,278,031	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Country Health

# 0007880

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,891,513	\$ 56,537		\$ 56,537	\$	\$ 1,278,031	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,017,721	\$ 56,537		\$ 56,537	\$	\$ 1,278,031	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$677,732	\$44,031	\$44,031	\$		\$617,744	71
72	Current Year Purchases	32,275						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$710,007	\$44,031	\$44,031	\$		\$617,744	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		1983 Chevy Van		\$18,305	\$	\$	\$		\$
77		1985 Ford		6,000					
78		1996 DODGE VAN		25,500					
79									
80	TOTALS			\$49,805	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	2,804,564
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	100,568
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	100,568
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,895,775

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_\*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 12,959 Description: pager, computer equipment  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training aides from other facilities.

		1		2		3		4	
		Facility							
		Drop-outs	Completed			Contract		Total	
1	Community College Tuition	\$	\$			\$		\$	
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$	\$			\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$							

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.



XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 128,156	\$		\$ 128,156	1
2	Licensed Speech and Language Development Therapist		hrs			10,788			10,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			337	95,295		95,632	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				59,902		59,902	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					12,754			12,754	13
14	TOTAL			\$		\$ 152,035	\$ 155,197		\$ 307,232	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 365,403	\$	1
2	Cash-Patient Deposits	9,897		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	335,785		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,527		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,674		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 745,286	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,031		13
14	Buildings, at Historical Cost	2,029,778		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	747,754		16
17	Accumulated Depreciation (book methods)	(1,895,775)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 908,788	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,654,074	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 118,425	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,897		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,365		30
31	Accrued Taxes Payable (excluding real estate taxes)	381		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 266,068	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	15,500		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 15,500	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 281,568	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,372,506	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,654,074	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,332,463	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,332,463	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	40,043	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 40,043	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,372,506	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,088,773	1
2	Discounts and Allowances for all Levels	(549,002)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,539,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	605,361	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 605,361	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,180	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,126	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 84,306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,574	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,574	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,232,012	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	640,959	31
32	Health Care	1,614,607	32
33	General Administration	878,431	33
	B. Capital Expense		
34	Ownership	113,977	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(56,005)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,191,969	40
41	Income before Income Taxes (line 30 minus line 40)**	40,043	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 40,043	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?                      If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	1,848	\$ 47,892	\$ 25.92	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,733	5,004	102,545	20.49	3
4	Licensed Practical Nurses	7,585	8,275	135,633	16.39	4
5	Nurse Aides & Orderlies	46,172	50,717	619,159	12.21	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,959	3,317	47,855	14.43	8
9	Activity Director					9
10	Activity Assistants	4,480	5,157	45,380	8.80	10
11	Social Service Workers	5,673	6,212	45,652	7.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,011	18,139	165,034	9.10	15
16	Dishwashers					16
17	Maintenance Workers	3,537	3,988	49,119	12.32	17
18	Housekeepers	9,251	10,301	86,862	8.43	18
19	Laundry	5,017	5,712	43,953	7.69	19
20	Administrator	2,000	2,080	61,959	29.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,075	8,572	114,820	13.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,277	129,322	\$ 1,565,863 *	\$ 12.11	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		7,200		36
37	Medical Records Consultant		1,430		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,190		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,430		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,250		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,846	\$ 55,375		50
51	Licensed Practical Nurses	1,860	46,506		51
52	Nurse Aides	4,343	86,868		52
53	TOTAL (lines 50 - 52)	8,049	\$ 188,749		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## **XIX. SUPPORT SCHEDULES**

[illegible]

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**



XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

no

(2) Are there any dues to nursing home associations included on the cost report?

yes

If YES, give association name and amount. 

Illinois Healthcare Association

(3) Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

7 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 

5,000

 Line 

10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES 

xx

 NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES  NO 

xx

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 

48,728

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 

0

 Has any meal income been offset against related costs? 

yes

 Indicate the amount. \$ 

7,484

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period. \$

(17) Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name: 

Sulaski & Webb

 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

no

 If no, please explain. 

Not available at this date

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees.